A REPORT ON
HMO REFERRALS IN MARYLAND

Presented to the

Health Care Access and Cost Commission

Electronic Data Interchange & Payer Compliance Division
Data Systems and Analysis

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EXECUTIVE SUMMARY

Nearly all practitioners recognize that EDI offers a number of cost-saving benefits. They contend, however, that practices cannot achieve the full savings from EDI because HMOs continue to require that paper referrals be attached to claims. In December 1998, the Health Care Access and Cost Commission (Commission) staff decided to seek input from nine Maryland-based HMOs and three provider-based organizations[1] to gain a better understanding of EDI use among practitioners and carriers. This summary is based upon meetings with HMOs and practitioners between January and July 1999.

Several important issues were uncovered because of these meetings. ***Providers are confused about HMOs' referral processing requirements and on HMOs' electronic processing capabilities in general.*** HCACC staff found that practitioners believe that HMOs do not support EDI, even though only a few HMOs operating in Maryland require that a paper referral be attached to a claim. These perceptions slow the adoption of EDI because payer inability to accept electronic claims will limit a practitioner's potential savings. ***The varying policies of HMOs on referral submission and electronic submission contribute to the confusion in the practitioner community***. Although some practitioners use opposition to the use of referrals as an excuse for not using EDI, the lack of consistency in HMO referral requirements makes EDI use problematic for many practices. ***The Commission staff believes that HMOs could further standardize electronic referral requirements. As a first step, the industry should develop a referral guide describing EDI and referral practices used by HMOs operating in Maryland.***

A related concern voiced by many practitioners is the slow turnaround in reimbursement and the enormous amount of paperwork and duplication that results from variation in HMOs' electronic claims processing capabilities. Many practitioners report hiring additional staff to process paperwork required by HMOs. The additional staff manages accounts receivable and provides HMOs with claims support documentation. According to the Maryland Group Management Association (MGMA), administrative support in practitioner offices increased from one to three

[1] Participants listed in Appendix I.

clerical staff per full-time physician over the last ten years.[2] On reimbursement, practitioners report that HMOs require approximately 60-90 days to process paper claims. In contrast, clearinghouses report the turnaround time for electronic claims is about 14 days.

Commission staff recommends that the Maryland Insurance Administration examine methods for enforcing the timely payment provisions (COMAR 31.10.23) of Maryland Law. The Commission staff further recommends that the Commission use its authority under Maryland Law (COMAR 10.25.07) to require all HMOs to accept claims and referrals electronically.

INTRODUCTION

According to the STATE HEALTH CARE EXPENDITURES: Experience from 1997, administrative health care costs accounted for 7 percent of the $15.9 billion in total health care expenditures for 1997.[3] A major source of administrative expense is associated with claims processing. Approximately 70 million health care claims were submitted to Maryland payers, but only 54 percent of all claims were submitted electronically. By increasing the use of EDI, Maryland payers and providers could significantly reduce the administrative cost of health care. Until recently, the private sector lagged government payers in adopting EDI. In 1997, private sector payers only accepted 37 percent of claims electronically compared to 79 percent for Medicare and Medicaid.

EDI growth nationally, and in Maryland, continues at a slow pace partially due to HMOs' slow adoption of electronic claims. Many practitioners cannot understand why HMOs have not fully implemented EDI when historically most fee-for-service claims were submitted electronically.[4] In 1998, even government payers were encountering problems maintaining high EDI use rates. Maryland Medicaid accepted most claims using EDI at no cost to the practitioner. In mid-1997, the Department of l Health and Mental Hygiene introduced ***HealthChoice*** using managed care organizations (MCOs) to administer the Medicaid Program. According to an ad hoc survey conducted by the Medical Care Operations Administration, during 1999 only one out of eight MCOs contracting with the state accept electronic claims.[6]

[2] Information reported to HCAVCC from the Reimbursement Committee at MGMA in July 1999.
[3] 1998 Health Care Access and Cost Commission EDI Progress Report.
[4] Information reported from MGMA's Reimbursement Committee, July 1999.
[6] Telephone survey conducted in December 1998 by the Medical Care Policy Administration under the Department of Health and Mental Hygiene, State of Maryland.

Several professional organizations report that EDI use reduces a practitioner's administrative health care costs. The Workgroup for Electronic Data Interchange (WEDI) estimates the average claims submission cost for practitioners is about $5 versus $1 for electronic claims.[8] These reported cost-savings should be view cautiously, however, since these amounts vary among professional organizations.

HMOs, EDI, AND REFERRALS: The Issues

Practitioners expect timely reimbursement and define this as approximately 30 days from claims submission. Many practitioners dedicate significant human resource hours to accommodate HMO requests for additional claims information and see the burden of paper referrals and support documentation on specialty services as a way to delay payment.

Many practitioners indicate that at one time medical billing was relatively easy to complete and not a full-time job. In fact, some small practices reported they relied on spouses to handle most of the fee-for-service billing. In today's market, however, they report they can no longer rely on clerical staff to handle the claims submission requirements of HMOs. Medical billing requires expertise in medical coding, claims compliance requirements, as well as PC experience.[9] Many practitioners feel that one way HMOs have reduced their health care costs is by shifting the administrative tasks onto practitioners.[10]

Some practitioners contend that HMOs also reduce their costs by requiring members to obtain a referral from their primary care provider prior to obtaining care from a specialist. Because reimbursement is uncertain, some practitioners request payment at the time service is rendered for patients covered by CareFirst Blue Cross of Maryland or Mid-Atlantic Medical Services, Inc. (MAMSI) who do not have a copy of their referral. Conversely, Prudential, Preferred Health Network, and CareFirst Blue Cross of DC are examples of HMOs that use more automated methods for notifying specialists of referrals including e-mail, FAX, and automated voice response system.

[8] Information reported by WEDI at the March 1999 EDI Convention in San Antonio, Texas.
[9] Information reported from MGMA's Reimbursement Committee, July 1999.
[10] Miller, F. H., and H. S. Luft. 1997. Managed Care Plans: Characteristics, Growth, and Premium Performance. *Annual Review of Public Health* 15:437-59.

Practitioners argue that growth of HMOs has decreased their incentives to use EDI in others ways, too. According to Dr. Refael Haciski, Chair of Computer and Medicine at MedChi, among HMOs that accept electronic claims, highly specialized services, such as infertility services, are routinely billed on paper due to the supporting documentation required by HMOs.[7] Many payers, including indemnity plans, require support documentation for such highly specialized services. Absent a national standard for electronic attachments, claims for these services will likely continue to be submitted on paper. It would be extremely beneficial if all payers defined the services requiring additional documentation. Practices also report difficulty with the submission of more routine services. Practitioners and practice managers openly express concern over the vast amount of follow up time needed for claims status inquiries.

Payers benefit from practitioner use of EDI. According to CareFirst Blue Cross of DC, EDI reduces processing costs by as much as 50 percent on a per claim basis. The disadvantages of paper claims also fall on payers. HMOs that require a paper HCFA 1500 claim, along with a referral attached, risk losing information necessary for adjudicating claims. These claims are manually keyed or optically scanned into a payer's adjudication system. Once in the system, a claim that appears incomplete is denied. Examples of HMOs that require paper billing include MAMSI and CareFirst Blue Cross of Maryland.

HMO REFERRAL PRACTICES

Between January and July of this year, HCACC staff met with nine HMOs handling substantial numbers of Maryland covered lives to discuss their referral process. In addition, HCACC met with three provider-based organizations; two of which participate in Medicaid ***HealthChoice.*** These meetings were typically attended by senior-level management, including general managers, chief medical officers, and chief information officers. In several instances, utilization review and quality management staff attended. To gather information from each HMO, HCACC staff conducted a focused discussion on the EDI and referral procedures of each HMO. A follow up questionnaire was also provided that asked these specific questions:

1. ***Do you require a referral attached to most claims?***
2. ***Are you able to reference a referral number on the claim?***
3. ***Are you able to adjudicate "clean" electronic claims in 30 days?***
4. ***Are you able to adjudicate "clean" paper claims in 30 days?***
5. ***Are you able to verify member eligibility electronically?***
6. ***Do you require members to deliver referrals to specialists?***
7. ***Are you able to issue a referral number in less than 24 hours?***
8. ***Do you use a voice response system for referral?***
9. ***Do you use the ENVOY Swipe Box for obtaining referrals?***

The Commission staff analyzed the 1997 Medical Care Data Base to determine the average number of days between the last day of service and claims adjudication date. This measure serves as a simple proxy for the days in accounts receivable. Longer average accounts receivable days place additional financial burdens on practices that depend on reimbursement to cover costs of delivering care.

Limitations

The validity of the information collected by the Commission is dependent on the accuracy of its HMO sources. In some instances, HMO senior management staff met with the Commission while line management attended other meetings. It is conceivable that senior management is not as familiar with operational process compared to line management. Commission staff identified the following areas as potential limitations to the method:

1. ***Inconsistency in the definition of a "clean" claim,***
2. ***Variability in the use of referrals, and***
3. ***Misunderstanding of EDI information system support.***

Because the significance of these limitations is unclear, Commission staff requested HMOs to verify the coded information contained in Table 1.

Findings

Most payers offer multiple systems aiming at particular categories of practitioners. Survey results reported in Table 1 indicate that seven of the nine HMOs offer some EDI options to practitioners. The largest HMOs, operated by CareFirst Blue Cross of Maryland, Mid-Atlantic Medical Services, Inc (MAMSI), and Prudential Healthcare express a willingness to accept electronic claims, but lack a vehicle for accepting electronic referrals. These organizations do not currently accept electronic referrals. For practitioners, a payer's ability to accept referrals electronically means the acceptance of electronic claims is of little value. Only one of the provider-sponsored organizations currently offers EDI options for referrals.

A number of hopeful signs also existed. As presented in Table 1, three HMOs enabled practitioners to code referral information on electronic claims: United Healthcare, Kaiser Permanente, and CareFirst Blue Cross of DC. Johns Hopkins Medicine, among the provider-based organizations, also supports the coding of a referral number on an electronic claim. This feature was characteristic of organizations that tend to promote EDI services based on the capabilities of their existing information systems. This system is probably the easiest for practices to learn and usually will not involve the purchase of additional equipment or a significant investment in staff training.

Several payers use more sophisticated approaches for processing electronic claims while using referrals to manage care. Prudential, CIGNA Healthcare, and Aetna U.S. Healthcare code referrals on the member's eligibility record in their data base. Referrals are linked with the electronic claims during the adjudication process. Because referral information is gathered separately and stored in the patient record, practitioners can submit claims electronically just as they would under traditional indemnity. Unlike the above group, these HMOs appeared more readily able to invest in ongoing modifications to their information systems. This solution offers some of the same advantages as the previous method, although a provider may be required to obtain a referral number for internal documentation.

An automated voice response system for obtaining a referral number is used by Kaiser Permanente, Prudential Healthcare, and Johns Hopkins Medicine. Automated voice response systems enable primary care practitioners to enter patient information over the telephone. Specialists

can obtain the referral number and approve visits using a similar process. Availability and features of the automated voice response system varied among the above-named HMOs.

Another popular method for obtaining a referral number is through the ENVOY Swipe Box that is used by Aetna U.S. Healthcare, CIGNA Healthcare, and MAMSI. Practitioners enter member information into a card reader, obtain a referral number, and receive a printout of the referral. The ENVOY Swipe Box varies in limitations specific to each HMO. In general, practitioners that use the ENVOY Swipe Box report that it does reduce paperwork for their administrative staff.

As the previous analysis demonstrates, many payers offer more than one method for submitting claims. Several payers, including Aetna U.S. Healthcare, Prudential, and CIGNA, appeared to target EDI options to specific categories of practitioners. For example, a voice response system might be recommended to a practice with a few covered lives whereas the ENVOY Swipe Box is recommended for a practice with higher patient volumes. Although different options are beneficial, this diversity contributes to confusion in determining which method is most advantageous to a physician's practice.

Patuxent Medical Group, Johns Hopkins Medicine, and MedStar, the three provider-based organizations require referrals for services provided outside their networks. HCACC staff found that these organizations were as a group no more supportive of EDI than HMOs. Each of these groups employs specific protocols for issuing referrals. At Patuxent Medical Group, a referral request ascends through five levels before it is approved. Johns Hopkins Medicine and MedStar also use a similar "tier" process for approving referrals. The entire review process for these medical practices takes less than 24 hours for both in and out-of-network care. However, each practice requires members to deliver a referral to the specialist that the practitioner must in turn attach to the HCFA 1500 claim.

TABLE 1
HEALTH CARE ACCESS AND COST COMMISSION
DATA SYSTEMS AND ANALYSIS
HMO Referral Questionnaire - July 1999

PROVIDER-BASED PAYER	Requires referral attached to most claims	References referral # on electronic claims	Adjudicates "clean" electronic claims in 14 days	Adjudicates "clean" paper claims in 30 days	Verifies member eligibility electronically	Requires member to deliver referrals to specialist	Issues a referral # in less than 24 hours	Uses voice response system for referral	Uses ENVOY Swipe Box for obtaining referral
AETNA U.S. HEALTHCARE	No	No	Yes	Yes	Yes	No	Yes	No	Yes
CAREFIRST BLUE CROSS DC	No	Yes	Yes	Yes	No	No	Yes	No	No
CAREFIRST BLUE CROSS MD	Yes	No	Yes	Yes	No	Yes	Yes	No	No
CIGNA HEALTHCARE	No	No	Yes	Yes	Yes	No	Yes	No	Yes
KAISER PERMANENTE	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
MAMSI	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes
PRUDENTIAL HEALTHCARE	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No
PREFERRED HEALTH NETWORK	No	No	Yes	Yes	No	No	Yes	No	No
UNITED HEALTHCARE	No	Yes	Yes	Yes	No	No	Yes	No	No
JOHNS HOPKINS MEDICINE	No	Yes	Yes	Yes	No	Yes	Yes	Yes	No
MEDSTAR, INC.	Yes	No	Yes	Yes	No	Yes	Yes	No	No
PATUXENT MEDICAL GROUP	No	No	Yes	Yes	No	No	Yes	No	No

Delays in Payment: A Related Issue

Practitioners expect payment within 30 days of services and are frustrated over the inability of HMOs to pay within that timeframe. Although HMOs report that they process clean claims within 30 days, practitioners disagree and report that nearly all claims take a minimum of 60-90 days before payment is received. The data reported in Table 1 shows that HMOs are committed to process a clean paper claim within 30 days.

Using the 1997 Medical Care Data Base (see Table 2), the Commission staff examined the average number of elapsed days between date of service and adjudication date. The results show that the average claims processing days by payer consistently exceed the 30-days requirement. The payment period ranged from a high of 81 days for NYLCare to a low of 39 days for CareFirst Blue Cross of DC. The overall mean for the industry was 63 days. These results demonstrate that significant delays exist between service and payment. Although these results must be viewed cautiously, they imply that either few clean claims are submitted or that few payers follow timely payment provisions under Maryland Law.

TABLE 2
1997 Average Days by Payer by Days
HMO Fee-for-Service Claims

COUNT	PAYER NAME	AVERAGE DAYS
1	NYLCare	81
2	Kaiser Permanente	78
3	CareFirst Blue Cross of MD	71
4	Prudential Healthcare	64
5	United Healthcare of Mid-Atlantic	63
6	MAMSI Optimum Choice	61
7	MAMSI IPA	58
8	Aetna U.S. Healthcare	56
9	Preferred Health Network	52
10	Principal Health Care	48
11	CIGNA Healthcare	41
12	CareFirst Blue Cross of DC	39

Note: Claims for which a payer was a secondary payer have been excluded from the analysis.

IMPLICATIONS FOR EDI IN MD

How accurate are practitioners' assertions regarding EDI use among HMOs?

Initially, EDI was introduced as a way of creating operational efficiencies for practitioners and payers. At one time, EDI significantly reduced the amount of time required for reimbursement.[11] It is interesting that the cost-savings benefits of using EDI rank second to practitioner beliefs that electronic filing speeds the reimbursement turnaround time. Many practitioners continue to submit on paper because they are unclear on the EDI capabilities of HMOs. Practitioners recognize the

[11] Information reported from MGMA's Reimbursement Committee, July 1999.

negative implications associated with paper billing and express dissatisfaction regarding inconsistencies among HMOs to fully implement EDI. Additionally, most practitioners quite simply do not understand why HMOs have lagged in implementing EDI services. Their assumption is that HMOs implement operational processes to delay reimbursement by unnecessarily requiring hard copy referrals and support documentation on many specialty services.

RECOMMENDATIONS

(1) Development of "HMO EDI Reference Guide"

Commission staff recommends developing an "HMO EDI Reference Guide" using input from HMOs, practitioners, and professional organizations. The information would be designed to assist practitioners in determining a payer's EDI service and would include:

1. ***HMO EDI capability and eligible specialty services,***
2. ***Claims coding examples, and***
3. ***Frequently asked questions.***

Because practitioners often lack a clear understanding of EDI capabilities among HMOs, they broadly assume they have none. The "HMO EDI Reference Guide" would provide practitioners with the necessary information to identify those payers offering EDI services. Since many practitioners reported difficulty in keeping up with HMOs' requirements on electronic claims submission, the reference guide would assist practitioners in determining the EDI capabilities of specific HMOs.

Commission staff recommends using professional associations, such as MediChi and MGMA, for distribution of "HMO EDI Reference Guides." Some professional organizations have already expressed interest in participating in the updates to the "HMO EDI Reference Guide" on an ongoing basis.

This recommendation directly responds to the frequent call from practitioners for more EDI information on HMOs. The "HMO EDI Reference Guide" would serve to broaden practitioner knowledge of payer's electronic claims submission requirements and potentially

narrow the gap in statewide use. If approved, the projected timeframe for the development of the "HMO EDI Reference Guide" is estimated at four months.

(2) Require HMOs to Accept Practitioner Claims and Referrals Electronically

Commission staff recommends requiring HMOs to accept practitioner claims electronically. As previously mentioned, a number of HMOs accept some practitioner claims electronically, however, most require specialty services be paper billed. Requiring Maryland-based HMOs to accept practitioner claims electronically from practitioners wishing to submit in this manner will increase EDI.

EDI Progress Reports contain vital information necessary for the Commission to track HMOs' EDI performance on practitioner claims. The Commission staff suggests a progressive approach. HMOs failing to meet the requirements in the first year would be notified in writing and for noncompliance in the second year a penalty would be imposed. This recommendation could require additional regulation action since it is doubtful that payers would voluntarily implement this initiative. Incorporating this recommendation into existing EDI regulations would require investigation by the Commission's legal counsel.

This recommendation is in response to the growing concern by practitioners that HMOs do not support EDI. Requiring HMOs to accept practitioner claims electronically reduces state administrative health care costs, and enables practitioners to maximize their EDI capability.

APPENDIX I

HMO Participants

1. Aetna U.S. Healthcare
2. CareFirst Blue Cross of DC
3. CareFirst Blue Cross of MD
4. CIGNA Healthcare
5. Kaiser Permanente
6. Mid-Atlantic Medical Services, Inc. (MAMSI)
7. Preferred Health Network
8. Prudential Healthcare
9. United Healthcare

Provider-Based Organizations

1. Johns Hopkins Medicine
2. MedStar, Inc.
3. Patuxent Medical Group